(This document will ONLY be accepted on the Examining Physician's letterhead).

MEDICAL STATEMENT FOR CONSIDERATION OF CARE GIVER OR CARE RECEIVER ASSISTANCE

Date: _____

Patient's Name: _____

Dear Doctor:

The above named patient has requested a temporary permit to allow a second residence on property because of extreme personal hardship. Generally, this is requested when, due to illness or other infirmity, near-by assistance is required for the patient's health and well being.

Please affirm if your patient requires personal assistance due to illness or infirmity:

_____ Patient requires assistance with daily personal care or would benefit from an on-site care giver.

_____ Due to the patient's condition, having near-by assistance immediately available is highly recommended.

_____ Due to health concerns, patient requires assistance with medical needs which require an on-site caregiver.

Other reasons: (describe briefly)

_____
_____
_____
_____

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT.
PHYSICIAN'S NAME & ADDRESS
(Please type or print)

_____
_____
_____

_____
Examining Physician's Signature